DRIVER CONDITION OR BEHAVIOR REPORT

Clear form

MV3141 9/2003

The following information is submitted for consideration as "Good Cause" for Departmental action as authorized under section 343.16 Wisconsin Statutes. Advanced age alone, cannot be considered as good cause. **Positive driver identification must be established.** License plate number only is **not** sufficient.

Submit To:

Wisconsin Department of Transportation
Medical Review
PO Box 7918
Madison, WI 53707-7918

Telephone: 608-266-2327
FAX: 608-267-0518
E-Mail: dre.dmv@dot.state.wi.us

M.D. or D.O.: Please complete back. All others, complete front.

This information may be subject to Wisconsin's Open Records Law.

Driver Name - First, Middle, Last	Birth Date	Driver License Number		State of Issuance
Address		**City**	**State**	**ZIP Code**

Driver Condition - Check appropriate boxes. **Describe below.**

- ☐ Physical Condition
- ☐ Mental/Emotional Condition
- ☐ Blackout, Seizure, Fainting Spell
- ☐ Lack of Knowledge of Traffic Laws
- ☐ Confused/Disoriented
- ☐ Alcohol/Other Drugs
- ☐ Defective Vision
- ☐ Obstructing Traffic

Describe in detail incidents or conditions which brought this driver to your attention. Give specific information such as dates, places, accident reports, all other available information to support the Department's action.

Type of Enforcement Action Taken	Incident Date	Time
Title and Signature of Person Completing this Form **X**	Print Full Name	Area Code - Telephone Number
Address - Please Print	City and State	ZIP Code

Print Full Name of Person who can **verify** the above information- Required if report is completed by private citizens or family members	Area Code - Telephone Number
Address	**City and State**	**ZIP Code**

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This side must be completed by an M.D. or D.O. only. Clear form

This information is not subject to Wisconsin's Open Records Law; it is, however, available to the driver upon request.

Driver Name - First, Middle, Last	Birth Date	Driver License Number		State of Issuance
Address		City	State	ZIP Code

Describe in detail patient's current medical condition(s) and diagnosis. Give specific information to support the Department's action.

YES NO

☐ ☐ Do you recommend a complete re-examination of patient's driving ability?

☐ ☐ Is this patient able to safely operate a motor vehicle at this time? A "No" answer will result in immediate cancellation of all license classes and endorsements.

Signature of M.D. or D.O.	Date	Print Full Name	Medical License Number
X			
Mailing Address		City, State, ZIP Code	Area Code - Telephone Number